

Building Trauma-Informed Connections via Telehealth During COVID-19

Transcript

April 29th, 2020

Tanya Schwartz: Hello everyone and thank you for joining today's ACEs Aware webinar. My name is Tanya Schwartz and I'm with Harbage Consulting, and we're very proud to be supporting the Department of Health Care Services and the office of the California Surgeon General on the ACEs Aware initiative. Today's webinar is on Building Trauma-Informed Connections To Patients Via Telehealth During COVID-19. Now, this is the third in a series of educational webinars that offer practical information for primary care and behavioral health providers on providing trauma-informed care.

Tanya Schwartz: I'll start with some very quick housekeeping items. If we run into any technical difficulties and get disconnected, please dial back into the webinar using the same link. Everyone is muted on the webinar but you can submit questions on the right hand side of your screen in the chat feature and we'll try to get to questions at the end if we have time. But any questions we cannot get to, we'll take back to inform our future communications. And finally, this webinar is being recorded, a recording, a transcript and the presentation slides will be available at ACEsAware.org by early next week. Next slide please.

Tanya Schwartz: So the ACEs Aware mission is to change and save lives by helping providers understand the importance of screening for adverse childhood experiences and training providers to respond with trauma-informed care to mitigate the health impacts of toxic stress. Now, this mission is even more important today as we address the stress and the other secondary health impacts related to COVID-19. And we know that stress levels are high for all of us right now, I know that they are in my family, and particularly for people with chronic health conditions as well as for vulnerable populations.

Tanya Schwartz: And at the same time, many patients are experiencing disruptions in their usual source of care. So it's really critical that primary care and behavioral health care providers continue to connect with and provide care to their patients even if they can't see them all in-person. Next slide please. Today, we're going to hear



from two physicians about how they are each using telehealth to build and maintain connections with their patients and provide their patients with the care they need during this time. So we're really pleased to have Dr. Dayna Long who is a pediatrician at UCSF Benioff Children's Hospital, Oakland, and Dr. Erika Roshanravan, a family medicine physician with CommuniCare Health Centers. And we're also pleased to welcome Lisa James from the organization Futures Without Violence.

Tanya Schwartz: Next slide please. Next slide please. So on today's webinar, I will provide some context for today's presentation. I will hear from our two physicians about their experiences providing trauma-informed care via telehealth, and Lisa James will talk about how to address domestic violence with patients via telehealth. And we'll end by highlighting the California Surgeon General's stress relief playbooks and some other resources that providers can use. Next slide please.

Tanya Schwartz: So to set the stage for today's webinar, it is important to understand the science of stress, how it gets under our skin and changes our biology and what we can do about it. Now, biology tells us that our stress response falls along a spectrum of positive stress, tolerable stress, and toxic stress. And so the stress and anxiety from the uncertainty around the COVID-19 emergency, compounded by the economic distress and social isolation resulting from measures to slow the spread can have short and long-term health impacts. Now, these include cardiovascular, metabolic, immunologic and neuropsychiatric risks from overactivity of the biological stress response.

Tanya Schwartz: And individuals with a history of adverse childhood experiences are especially vulnerable. So it's important that we all do our best to manage our own stress and help our patients manage their stress, including through increasingly use of evidence based interventions that Dr. Long is going to talk about today. Next slide please. Thank you. Without support to buffer toxic stress, this stress and anxiety that people are experiencing may result in an increase in the prevalence of adverse childhood experiences in children such as intimate partner violence, child maltreatment, and substance misuse.

Tanya Schwartz: It could result in a toxic stress physiology like I just talked about, as well as toxic stress related symptomology that patients may present with, as well as negative mental and physical health outcomes. Now, these outcomes can be compounded when people delay or avoid seeking care out of fear of contracting COVID-19, including preventive care, support for chronic health conditions and

medications, and when access to needed resources is disrupted such as nutritious foods and safe places for physical exercise.

Tanya Schwartz: I want to note that California is particularly focused on addressing the impact of COVID-19 on the health of communities of color. Research shows that adverse childhood experiences and cumulative adversity increases the risk for underlying health conditions, and the physiology that increases the risk of dying from COVID-19. So today, Dr. Long will talk about these health disparities and this is an area that ACEs Aware will wearable continue to focus on in the months ahead. Next slide please.

Tanya Schwartz: So for all of these reasons, primary care and behavioral health providers have a critical role to play in supporting your patients at this time. So today, our presenters are going to talk about how they are building connections with their patients and supporting them using telehealth during this time. And so with that, I will turn it over to Dr. Dayna Long.

Dr. Long: Thank you so much, Tanya. And I'm very excited to talk about how we are providing trauma-informed care during this era of telehealth. This photograph is really a timestamp for me of our primary cares experience with COVID. Many of us remember the day that we found out that our schools were closed, that our children would be home, and that our lives as providers was going to dramatically change. This picture was taken on March 16th, which feels like a lifetime ago for most of us. And what you see is a canopy tent where we are starting to do pre-screening for all of our families prior to entering clinic so that we can cohort our sick children from our well children.

Dr. Long: And as we were establishing our clinical protocols, this Corona Extra Beer truck drives by the front of our clinic, and we thought it was particularly ironic that this truck would drive by as we were developing our screening protocols for COVID. Next slide. The Trauma-Informed Organization came out with this slide that really acknowledges that we are in the midst of unprecedented times, that we have to acknowledge that we are each holding a multitude of feelings, responsibilities, fears and joys.

Dr. Long: We acknowledge that we all have many responses to stress, and each of those responses is valid, that we have an opportunity to actually practice compassion and collective care right now and that that is our work as providers, and that we acknowledged the critical need for our own self reflection, inquiry and prioritization of the most critical needs. This presentation that you're going to

hear today is very different from the presentations that most of us give as clinicians where we talk about clinical protocols or case studies or research or data. This talk is very much about our own emotional cores and reaction to the environment in which we now find ourselves working. Next slide.

Dr. Long: As providers, we are committed to serving our families and getting through this together. For those of us that right in healthcare, we have a multitude of feelings right now as we balance our professional and our personal demands, and sometimes these feelings are conflicting, the demands of our families and the demands of our profession. We have fears about infecting our families from the patients that we serve. We have fears about the implications of what it would mean if we have to self quarantine. And I recognize that we are such a dedicated group of people with a strong service orientation and in these difficult times we often ignore our own needs, and this is just a shout out to make sure that we are all taking care of each other. Next slide.

Dr. Long: So I'm going to talk about why it's so important that we stay connected to our families. I'm going to give examples of practice transformation, talk about my own tele-medicine experience and then share into straight guidance for our families. Next slide. My clinical practice is within a Federally Qualified Health Center. And within our FQHC, over 90% of our families are on Medicaid, over 90% of the families that I serve are also families of color. And what we do know is that across the country, there are stark disparities that are being revealed by the Coronavirus' data. These preexisting inequities really highlight that African American's are particularly disadvantaged and more disposed to morbidity and mortality secondary to COVID.

Dr. Long: The reason why I stay connected to my families is that this virus is exposing these health inequities such that in majority counties where African Americans live, there are six times the death rate in other counties. Next slide. We do have very evidence-based hypotheses about why African Americans and people of color are being hit harder by COVID. What we do know is that low income communities and people of color often have higher rates of underlying health conditions, and these health conditions range from asthma, diabetes, hypertension and obesity, and COVID exasperates these challenges.

Dr. Long: We know that people of color are more likely to work in essential jobs that put them in closer contact with other people, making it more difficult to have the six feet of social distancing. We know that within communities of color, there often is inadequate information that gets disseminated, there's a lack of trust and

mixed messages, and that the determinants of health such as food insecurity and housing instability are huge stressors right now that are compounded by the stressors that we're all facing within this pandemic. Next slide.

Dr. Long: So what we do know, particularly in California, and this slide is the most up to data from the California Department of Public Health is that you see that African Americans make up 6% of the population in California, and yet we we are almost twice, we are 11% of the deaths in California secondary to COVID. Next slide. Within our Federally Qualified Health Center, we very quickly shifted our new normal. We immediately formed a crisis command center, and all of senior leadership was very aligned and very evidence based and fluid in how we were actually responding to this virus to ensure the safety of all of our resident doctors, our attending doctors as well as our pediatricians.

Dr. Long: We have daily huddles both morning and night, every morning at 8:30 and every afternoon at 4:45, and we are in constant contact with one another. Fortunately, at Children's Hospital, we had been practicing trauma-informed care and had been building our capacity to be a trauma-informed system. And because we had built in these tools into our system, we now rely on those tools every single day. Next slide. So we quickly transformed to mobilizing what was a very limited infrastructure for telehealth to be a fully functional system. We quickly trained all staff, and this staff ranges from the registration clerks to the office assistants to the licensed vocational nurses, to the nurse practitioners, to the providers.

Dr. Long: And we have been able, thankfully, to actually maintain care for our patients. So that first week in March, we were seeing about 190 telehealth visits per week within our hospital system, the ambulatory system. And as of last week, we do about 3,750 telehealth visits per week. We often make assumptions about our families, particularly our families of color that, "Oh, they won't be able to access telehealth, they won't be able to download the platforms." And what we know to be true is that is not true, that our families are immensely resourceful, our families are savvy. And if given instructions in the appropriate language, they are actually quite adept at doing telehealth, honestly.

Dr. Long: Our families are often young and they are actually much more savvy at technology than some of us older attendings. We know that most families do have smartphones, and if families cannot actually get on a video conference, we can do a remote visit over the telephone. Next slide. We've also shifted our notion of team-based care. At UCSF Benioff Children's Hospital, Oakland, we

long have had a navigation program. And navigators are care coordinators that help to provide resources, referral, case management and follow up around unmet basic needs and community-based mental health needs.

Dr. Long: We were able to pivot our care coordination programs so that they also are working virtually. We do always have a navigator in-house to help families who actually come into clinic, but we also are able to call families, email families, text families with resources. We have found that we've changed the types of resources that families are requesting, and so we've always provided families with food, we've helped families get into nature through working with our local park district, we've helped families with activities, but more and more, we found that getting families access to unemployment applications and filling out those applications with families has been really critical.

Dr. Long: We've focused a lot on technology to make sure that our families have email addresses, that they're signed up for, what we call My Chart so that they can actually have access to their medical record, to request refills, to set up appointments. We also have been helping families with internet access so that all of our children can be learning at home. We have really robust food programs at our clinic so that we have these food pharmacies so that... We always were having this farmer's markets twice a month within our clinic, but those farmer's markets have shifted to drive through farmer's markets. And I have to say, last week we give out 400 bags of food to our families. And being able to serve families' unmet basic needs is a really important part of the work that we do.

Dr. Long: Next slide. I had referred to these trauma-informed tools that our staff has been working on developing. And in collaboration with Dovetail Learning, we have three pillars of tools, and these tools are related to centering, connecting and collaborating. What centering means, it really is the practice of bringing oneself into balance of centering and listening to our own internal cues, of accepting what is true, of being kind, of finding gratitude and finding a way to move forward, that includes self-awareness, self-regulation, self-trust, self-empathy and forgiveness.

Dr. Long: This notion of connecting, it's about the practice of building relationships and of creating intimacy within those relationships, of connecting and feeling like we are a belonging to this human core and that we are more accepting of ourselves as we normalize and move towards common goals. And lastly, collaborating is really the experience of having a shared purpose and all acting for the common

good. As we have made so many changes so rapidly amongst our staff, we have relied on the principles of centering, connecting and collaborating, and they really have been able to get through. Next slide.

Dr. Long: So as I said, we've been practicing telehealth, it's now been about five weeks. And my experiences with telehealth are that it is an intensely humbling experience because we actually are being welcomed into the home of families. We can actually witness the whole family being together, and especially within my patient population, really highlighting the disparities and inequities as we hear families sharing that they don't have enough food or they don't have transportation or they don't have the ability to socially distance because they're living doubled up with many other family members.

Dr. Long: I have patients that I've seen recently who have grandmothers or grandfathers on oxygen who needs care but aren't able to get it or who require dialysis daily but no longer have the transportation. I have witnessed this mutuality of relationships. My families are so grateful to see me on video, and I see their faces light up when I'm actually in the home with them. And I feel the same, I feel an immense amount of gratitude to be able to see them on video as well. I was seeing a teenager the other day and we had a fantastic conversation, and as I was ending the call, he didn't know that I could hear him, but I heard him say to his mother, "That was so fun." And so families want to stay connected to us.

Dr. Long: We also have the opportunity and the time now to listen to our families, and lastly to provide education. Next slide. The education that is so important for our families to hear right now is that they are enough, that they are doing a great job and that they have an immense amount of resilience already. It's really important to focus on caregivers as buffers, and what are those protective factors and how social connection is actually healing and therapeutic. We talk a lot about knowledge of parenting and child development and meeting your child where they're at. We are providing concrete support in times of need and also focusing on the children and enabling the children to be a part of the visit and talk on the call about how they're doing. Next slide.

Dr. Long: As Tanya mentioned, I am one of the principle investigators for the PEARLS tool, which is now the only tool in the country to be incentivized by a state and as part of the creation of the PEARLS tool from 2015 to '16, we did a bunch of pilots. And one of those pilots was where we interviewed attending positions on what do they want to say about ACEs and toxic stress in the form of anticipatory guidance. After we did several interviews, we looked for themes, and those

themes actually were related to this acronym that we developed from them called NOTE. So the N stands for noticing the relationship and the strengths between the caregiver and the child. And this can be done through telehealth. Oh, look how excited they are to spend time with you. It's so nice that you guys actually have the time now to connect.

Dr. Long: The O stands for offering the science, and what we say is that what we know is that ACEs and trauma affect our hearts, our minds and our bodies. Talk about the physiology of toxic stress. T stands for tools which we're going to talk about next. And E stands for empowering. You are a good parent, you are doing a good job. You got this. And I'm here in it with you. Next slide. So the tools that I was referring to are the tools about how when we have a toxic stress physiology, when our sympathetic nervous system is overactivated, how do you actually flip to get your parasympathetic system back on track? And a way to do that is through self-regulation, through having established rhythms, shared meals, exercise, sleeping, limiting your media, through connecting through healing relationships, and having a future-oriented perspective to focus on what I can do today in order to support tomorrow. Next slide.

Dr. Long: Our amazing Surgeon General in the state of California recently published a playbook for stress release during COVID. And in that playbook, there are six tools that are outlined. So the first is supportive relationships about staying connected to community. The second is about daily exercise and we all know that gyms are closed, but exercise is about doing jumping jacks or exercise videos in your house, going for walks, dancing with your children. The third is sleep hygiene, to make sure that we are getting good sleep at least eight hours a night.

Dr. Long: The fourth is about nutrition, and this isn't about nutrition like, "Oh, I need to diet," which we all might think in the back of our heads, but this is about nutrition and recognizing that when we are stressed, there's a biologic response, we have elevation of cortisol, we have a desire to reach for high fat, high calorie foods, which only actually make the toxic stress response worse because we have more unstable blood sugars and those blood sugars can make conditions such as diabetes worse.

Dr. Long: The next is about mental and behavioral health support to actually really engage in mental health care. Schedule an appointment with your provider, get a referral to a telehealth mental health clinician. And the last is about mindfulness, meditation and prayer. What we know is that mindfulness is

actually an evidence-based behavior. It can help to strengthen brain pathways that can actually buffer the stress response and help regulate our responses much better. Next slide. So in order to do stress busting at home, we have to focus on the awareness of how stress is showing up in our bodies as well as in the bodies of the children that we take care of.

Dr. Long: There's an exercise that I train families to do, it's called 4-1-5 breathing. And what that exercise is, it's a way to actually get back into your body and yourself and your executive functioning. And so the idea is that you breathe in for four seconds, you hold that breath for one second, and you breathe out for five seconds. It's called paced breathing and it's a very good way, you can even do it from your desk at home anytime. It's a very good way to ground yourself. The next is to make a plan and try to stick to it. Next slide.

Dr. Long: I'll quickly go through the recommendations for things to embrace and things to limit. We really want to embrace each other. Embrace our supportive networks, to take those deep breaths with 4-1-5, hydration. The art of play, be silly. Be silly with your family, watch a silly movie, make up a silly dance. And then being able to actually ask for help. And sometimes we all just need a moment. It's okay for us as adults to take time out for ourselves. We really want to limit the news. The news can be very challenging right now. We want to limit substances and those high fat, high calorie foods. Next slide.

Dr. Long: The Center For Disease Control has put out some tips for caregivers to support children. How important it is to be honest and upfront with your child and talk about what's going on with COVID, to make sure that we're sharing facts, and then to reassure your child to say, "I got you and I will keep you safe." And then we have to role model behavior. Our children watch us, make sure that we are taking breaks, that we are getting exercise, that we are sleeping. The next slide is the beautiful picture that was drawn by Kadir Nelson. And Kadir Nelson has written a number of children's books.

Dr. Long: And the picture is his response to COVID, that everybody has their eyes on the same prize, that we are all aligned in our common goal to through this together, and it really is a celebration of the human spirit. So thank you so much. I'm looking forward to answering questions and I want to pass it on to the next speaker. So Dr. Erika Roshanravan, it's your turn.

Dr. Roshanravan: Thank you, Dr. Long, and hi everyone and thank you so much for joining us today. I'm very excited to be here and share with you some of the ways that we

have been connecting with our patients during this time of COVID-19. I will be talking about some of the tools that I have found particularly useful and practical when I'm doing phone visits for how I can connect with my patients to make them feel heard and safe during this time. I will also be talking about our collaborations with our integrated behavioral health clinicians in our community and how we can actively reach out to some of those who are most in need. Like Dr. Long, I also work at a Federally Qualified Health Center where we serve many of our counties most vulnerable people.

Dr. Roshanravan: What brought me here today, talking about all these started 12 years ago when in residency, I started assembling my toolbox for life as a family physician. In my mind, I started flagging certain concepts and tools that seemed particularly practical and useful and important to me for my future as a family physician. Next slide please. Next slide. These MVTs or most valuable tools, they included things such as agenda setting, motivational interviewing, and of life care discussions or basic CBT skills. It included the mindfulness-based stress reduction course that we were lucky enough to attend, and introductions to things like medical improvisation and writing.

Dr. Roshanravan: It also included the introduction to the ACEs and how we can use positive discipline tools during well child checks to help break the cycle of family violence. Over the years working at community health centers, I have been using some of these tools every day because they are so practical and useful. And then COVID-19 arrived and really turned our world upside down. Next slide. Like many clinics across the country, we practically overnight changed the majority of our patient visits to phone visits and are now adding video when possible. And as we were launching into this novel world to me of phone visits, I was wondering which ones of my MVTs, of my Most Valuable Tools, would be practical and useful to apply to this new situation. Next please. During in-person visits, there are four tools that in my mind stand out to allow me to connect with my patients and to make them feel heard and safe. And all four of them are so practical and some of them really simple that I use them with almost every patient. These four are under usual circumstances is, I take a couple of deep breaths while I sanitize my hands before I enter the room.

Dr. Roshanravan: When I'm in there, I make sure to sit down and turn my body towards the patient. And then I share control over the visit by agenda setting and by shared decision making. Next. When I apply these tools to phone visits or virtual visits, it may look something like when I called Mr. G a couple of days ago to follow up on his diabetes and his blood tests. Before I called him, I took a couple of deep

breaths, and when he answered the phone, I virtually sat down with him, I said, "Mr. G, is this still an okay time for us to talk?" And then we went into agenda setting, I said, "Mr. G, I know we scheduled this appointment to follow up on your diabetes and on your blood tests, but before we get started, is there something else you would like to talk about today?"

Dr. Roshanravan: After that I will keep asking him something else and something else until Mr. G tells me dad that the list is complete and he will indicate his priorities and we can start organizing the visit. And lastly, I will engage Mr. G in shared decision making to make sure he's engaged in the plan and makes the decisions with me. I particularly want to point out the agenda setting for the purpose of these phone and video visits because it's harder for me to get a sense for where the patient is at and what is really going on. And so to agenda setting when you're not used to doing that, it may feel like a terrible idea, that's like opening Pandora's box that will make the visit go on forever. However, I have found to be really true what my mentors have told me years ago when I first was introduced to this concept of agenda setting, which is one, Mr. G feels heard when I do this.

Dr. Roshanravan: And two, countless times, it is not until reason four or five that the patient tells me what is the real reason why they are there today and what they really want to talk to me about and had I not kept asking I would never have found out. And this is the point that I find particularly true for phone visits because I may not have this sixth sense over the phone that there may be something else going on. And three, agenda setting makes my visit so much more organized and structured that in the end I often end up saving time. All of these four tools if I use them intentionally are just as easily applicable to visits or video visits as they are in person. And it is worth noting that especially the share of control tools are particularly important during this time of uncertainty and loss of control and as they empower the patient and reassure them. Next slide.

Dr. Roshanravan: Telehealth can also really remove some barriers to care. Many times when I call patients I hear tractors running in the background because they are calling straight out of work, from their work in the fields or other patients who are notoriously no showing suddenly are consistently showing up to their phone visits just because we removed the barrier for them to need to arrange transportation to come where I am at. Next slide. But despite my best efforts at agenda setting and those in the patient's agenda, there's always things that will only come out when I ask directly. And they do encourage you to name the elephant that's in the room, that is COVID-19. I will ask Mr. G, "How are you and

your family dealing with this shelter at home situation? Are you safe? Do you have enough food? And how is your mood?" Next slide.

Dr. Roshanravan: As Dr. Long has talked about, it has been really shaking the most basic needs of many of our patients and our staff through fear of illness and fear for loved ones, loss of income, loss of relationships, uncertainty, and in some cases, even domestic violence. And this is why I am really feel very grateful to live in an area where we have very strong community partners who help us to meet our patients' most basic needs? Next slide. This is a list of some of the organizations that have really stepped up during this crisis to help patients meet those most basic needs. Because when those needs are not met, it's very difficult for anyone to focus on things like chronic condition control.

Dr. Roshanravan: And I can tell you it was one of the highlights of my career as a physician when last week I saw a patient for a hospital follow up and she had been admitted for completely uncontrolled blood pressure and diabetes and she was discharged to the home of a family member where she was couch surfing, but after conflict, she moved back into her car and she did not bring her medications with her. So when I saw her, her blood pressure was, again, super high and her blood sugar very high, and that is not at all unique to COVID-19. However, what was unique and what was different is that now I had this piece of paper with an emergency housing plan from the county with a phone number that she got on the phone right then and there and five minutes later, she left to a motel room where she has a fridge, where she can keep herself on her medications safe.

Dr. Roshanravan: That is some of the collaborations that we have been having with our community that have really stepped up to meet those most basic needs of our patients. One of our most critical collaborations is with our own integrated behavioral health clinicians, and even before COVID-19 they were really critical part of our team and many times, we do warm handoffs and to connect patients with behavioral health services. Now, during phone visits, I will often talk to patients about this and ask them if they would like counseling or behavioral health support, And if they do, I can do a virtual handoff to integrate a behavioral health clinician, they would contact a patient and set them up with services. Next slide.

Dr. Roshanravan: We have also started to actively reach out to some of our patients and identify patients who have prior mental health conditions or risk factors such as homelessness, domestic violence, substance use, or trauma history. And one of our integrated behavioral health clinicians calls them to check in and to offer

them behavioral health and primary care services. In a separate effort, we are starting to reach out to patients with other chronic conditions that have not been seen in the last three months so we can help them better manage their conditions during this crisis to the best of their abilities. Next slide.

Dr. Roshanravan: I firmly believe that as primary care clinicians and behavioral health clinicians, we are in a very unique position during this crisis. We are playing a critical role in preventing a secondary wave of morbidity or mortality that comes both from stress-induced conditions as well as conditions that come because care is delayed. And the second reason we are in a real unique position is we know these families and we know these patients. That makes it so much easier for us to connect with them over the phone or over a video visit. And we might be able to identify who was struggling already and who might really need us to reach out to them right now. And lastly, we can be a calming and caring presence and a reliable source of information during this time for our patients and our communities.

Dr. Roshanravan: And by doing that, we can reduce stress for individuals and for families, and reducing stress can reduce conflict and ultimately violence. And with that, I turn it over to Lisa James, who will be talking more about how we can help reduce domestic violence. Thank you.

Lisa James: Thank you. Thank you so much for your presentation and to the organizers, and for all of you for joining this conversation. I think some of the strategies that have been shared in the experiences that have been shared around how to provide trauma-informed telehealth are particularly relevant for the work that we're doing to address intimate partner violence. And in some ways, I feel that the personal connections that both Dayna and Erika had just spoke about really opened the door for further conversations about healthy and unhealthy relationships in a new way. Next slide, please. And I want to underscore Dayna's point that now more than ever is the time for compassionate and collected care.

Lisa James: And this is particularly true when you're reaching out to survivors of intimate partner violence because as providers, you might be the only one who this patient is allowed to speak to outside of their home. And you might be their first responder, the first time to have a kind word in over a month, and the only access to information, health and safety. So you're playing a really critical role. Next slide, please. And so when we think about this unique role and when we bridge that with what we're unfortunately learning about the increases in violence during the pandemic, it's vital that we don't ignore intimate partner

violence, but it's also critical that we do so, we address it in a way that doesn't cause further harm or put patients at risk. And so we want to be able to do this well and to do this safely, and we don't have a lot of information about the safety of screening for intimate partner violence using telehealth, but what we do know is that people who use violence, use a whole host of strategies and ways to monitor and coerce their partners.

Lisa James: And that can play out when we're offering telehealth visits. And so we know that people who use violence might listen to the visit, might monitor texts, might monitor web history, and we've also even heard from some of our colleagues and advocates that sometimes abusers impersonate the intimate partner violence survivor in order to gain access to their health records or appointment times. So again, there's just a whole host of strategies that abusers use as a means for control. And because of that, we want to be really careful with how we address violence in these settings. I'm also going to talk a little bit later about how people who use violence are also using the pandemic to get in the way of healthcare access, and some of the stress busters that some of the previous speakers talked about, but I'll get to that later. Next slide, please.

Lisa James: In order to address the violence, but decrease the risk for retaliation, we are strongly recommending universal education instead of a screening tool for domestic violence. And the reason that we're going in that direction is it means that all patients can receive information regardless of whether or not they feel ready to disclose. And I think this is particularly important when we're working with populations who have a very valid history of distress in systems responses. So it's opening up that conversation and giving the information but not pushing for the disclosure. It's also encouraging our patients to help us spread the word and share the information with their friends and family members, really recognizing their role as leaders in the community to prevent violence in their community.

Lisa James: And this actually impacts our increased advocacy as health providers as we pass the word onto our patients. And it's also been playing out in an interesting way around really looking at the power dynamic between providers and patients. And I'm really struck by Dayna's point around the mutuality of relationships, and I feel this is another example of that. We're really giving over that shared power around providing information and resources on violence prevention and where you can get help, and putting the power of the visit in the hands of the patient. Next slide, please.

Lisa James: Another piece that we're learning a lot about is the healing power of altruism and that the science is really teaching us more and more that people heal better and quickly when they help out others. And this is true during a crisis situation as well. So again, not only if we provide universal education and resources around intimate partner violence to all of our patients, not only those who disclose, we're offering this opportunity for them to receive the information but also to share and help others, which has been very beneficial. Next slide, please. In thinking about, Erika's plan, the virtual plan to be present when you begin a visit, I want to add to her grounding exercises, establishing a private base where possible to have the visited, making sure that you check in that the patient that you're working with is in a space where they can speak freely.

Lisa James: And thinking through strategies where they might go to have more privacy in order to have this conversation. I think it's important to say that for survivors or victims of domestic violence, this isn't only about privacy, but it's also about safety. It's absolutely critical that we have a safe space and private space to have conversations, even if you're providing universal education and not screening directly. Otherwise, there might be a risk for retaliate. So work with them, consider some strategies to have a private space and trust your intuition. If you're not finding that, then schedule a different time for discussion. Next slide, please.

Lisa James: Similarly, in terms of confidentiality, it's critical to acknowledge that the medical information is confidential just like it would be in a clinic setting, but acknowledge those limits of confidentiality as well. And again, for providers who are identifying domestic violence, it's absolutely critical to disclose any limits of confidentiality prior to the visit so that the patient knows and can choose what they wish to share in that visit. And again, this is an issue of safety as well as privacy. And you have some scripts here, we have additional scripts on how to tailor your script, if you will, for disclosing limits of confidentiality as they relate to your states, reporting requirements. And then again, shifting back towards the conversation around COVID, and just really acknowledging that unfortunately the stress of this pandemic is actually offering us an opportunity to connect more personally with our patients and clients and open up the door about stress, and how it's impacting health.

Lisa James: And that is a bridge again to a conversation around intimate partner violence. So starting with knowing that COVID is a hard time and how has it been for you. Next slide, please. And then building off of that to a connection around intimate partner violence. So I offer this script again, each of you would adapt in your

own words, but just to give you an example of what universal education might look like, you could lead by acknowledging the stress of our current situation, and because of this stress we're sharing information about resources that are available to you or your friends or family members. For example, we might experience stress in our relationship, including increased fighting or harm, and that can impact our health. So I want you to know that there's help available for you or someone you know who might be hurt in their relationship.

Lisa James: "Would it be okay if I sent some of those resources to use to share? I will also send information around support, around parenting, access to food, and then stress." So again, making that information widely available, it does not require anybody to disclose what's happening to them unless they're ready to, encouraging them to share that with their friends and family members has been a really critical point of making sure that this is a de-stigmatized message for our patients, and the normalizing of this conversation around how relationships impact your health. And again, you can still ask directly about how things are going, it's just that once you offer the universal education, you've made some space to let the patient decide what they think is safe to share. Next slide, please.

Lisa James: And in many cases, people either may not be experiencing violence or they may not be feeling comfortable to talk about that at this moment. And so if that's the case, then accept the response and say that you're glad to hear that things are fine that you're always there for them if they need resources. And if they want to share the information, again, bring it back, "Would you like to help us by sharing the information with your friends and family?" And passing that on? Next slide, please. When you offer to share, do think through a little bit about what's the safe way to communicate with your patients. Ask them if it's safe for them to receive a text that has information about access to food, stress or domestic violence organizations.

Lisa James: If you're using the computer ask them whether or not you can enter that into the chat function. I know a number of our partners have been using the virtual waiting room to provide some basic information about where you can access some of these services. So again, thinking through some of the strategies to offer that information safely. Next slide, please. I do want to underscore that we've been working with healthcare providers for many years now around this universal education approach, we refer to it as Accused Approach and I can send out information about Accused Approach and the evidence that supports it. But even when we provide universal education, disclosures do happen.

Lisa James: So it's critical to be prepared to know what to say if somebody does say, "Yes, I'm struggling in my relationship." Or, "I am feeling unsafe." By offering some of those supportive messages that you see here on this slide, making sure that they know that you're sorry this is happening to them and that they don't deserve this, it can go a very long way in terms of building trust and making a bridge towards longer term support and resources. Be sure if you're talking during the telehealth visit, if they do disclose, to let the patient know that if at any point during the visit they need to change the subject rapidly, you will follow their lead. So that they know that they will be safe to shift over a conversation if they need to.

Lisa James: And earlier I talked a little bit about considering partner interference, why you create a care plan, to think through some of those stress busters and how might an abusive partner be interfering with efforts to stay safe in the context of the pandemic. And we are learning more from our advocates across the country around how people who use violence are using the pandemic as another means for control. That includes limiting access to hand sanitizers, limiting access to the computer for connections with friends or family, misrepresenting the shelter in place responses, and so forbidding people to go out for a walk and get some exercise outdoors.

Lisa James: So again, all of these strategies to further isolate the partner may come into conflict with your recommendations around staying healthy and safe. So work with the patient to figure out a care plan that might take this into consideration and create some new strategies with them and with an advocate if they're interested. Next slide, please. And the advocacy piece is important, I do want to underscore that I encourage you very much as we've heard from the previous speakers to think about their domestic violence programs as part of that team-based care. I want to underscore that our programs are up and running, reach out to your local program and find out how they're operating in the context of COVID and know that no matter what, the national hotline is up and available to provide services to you all if you have questions, to your survivors that you might be identifying and to those who are using violence as well.

Lisa James: So you can offer to connect the patient right then and there to an advocate if that's something that they're interested in, similar to the story we just heard about connecting up with housing. Next slide, please. Think of those advocates as critical resources for you, just like the stories that you all heard around telehealth, our advocacy programs have gotten up and running to provide virtual advocacy largely so you're not doing this work alone. And then finally, as

you end the visit, I want to offer some strategies that you can offer to the patient who might be worried that they don't have privacy in terms of their communication. So encouraging them to delete texts, to clear their browser history, to maybe consider using certain numbers like hotline numbers under a different name, like the name of the local grocery store.

Lisa James: Do some brainstorming and/or lean on your local advocacy programs to help think through some of those. And I just want you to see this resource put out by the National Network to End Domestic Violence, they've got a lot of in-depth information about tech safety and technology and privacy in the context of domestic violence. Next slide, please. I want to just end by underscoring these important takeaways. I just want to make sure that if nothing else, you know that by making sure that every patient has knowledge about where they can get help for domestic violence and where they can share that with their friends and family members. By doing that, by offering a warm referral and a supported referral to your advocacy program, if somebody does disclose and by working with them on their care plan that takes partner interference into consideration, you will be offering a critical, critical intervention and it really can be lifesaving.

Lisa James: So knowing and letting your patients know that you are there for them, that you have colleagues in your community who can also help, is absolutely critical and you have an opportunity to do this via telehealth in a way that's safe. And we really encourage you to keep doing that amazing work that you're doing. Next slide, please. I'll just end with some resources, I want to let that we have a number of resources that are related to COVID and intimate partner violence and specifically to telehealth. And you can click on any of these and also reach out to me directly. And I also want to thank Dr. Leigh Kimburg, Rebecca Levenson and Leigh Hofheimer, for their contributions to some of the thinking that I talked about today. Thank you.

Tanya Schwartz: Great. Thank you so much Lisa and thank you all for your wonderful presentations. I just want to share a few resources that are now posted on the ACEs Aware website. First, I'm really excited to share that the PEdiatric ACEs and Related Life-events Screener, also known as PEARLS, which was developed by the Bay Area Research Consortium on Toxic Stress and Health, has been posted on the ACEs Aware website in English, Spanish and in 15 other languages. And so these can be found on the website under the Screening Tools. We've also updated our resources on COVID-19 and stress, so please make sure to check those out. One of those includes a document on outreach strategies. We've been hearing from providers that you all are thinking about ways to proactively

reach out to your patients, and so we have developed a list of outreach strategies that providers can use.

Tanya Schwartz:

I'm including a list of vulnerable populations you may want to consider doing higher touch communication with, as well as a sample message to patients that you can tailor for your practice or clinic. We also posted an Academy of Communication And Healthcare Resources that is a script of language that providers can use to communicate with patients about COVID-19 using telehealth. And then next slide as Dr. Long mentioned, the California Surgeon General released two playbooks on stress relief, one for adults and one for families and kids. And I have found the self-care template to be really helpful both for me and my family in terms of setting goals for the day. So please make sure to take a look at those. Next slide, Lilly, and you can actually move to the next slide. Great.

Tanya Schwartz:

And so for the latest information on COVID-19 in California, please visit [COVID-19.ca.gov](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19). And next slide, Lilly. As I mentioned earlier, this is the third in a series of educational webinars, so we hope that you'll continue to tune in on the last Wednesday of each month from 12:00 to 1:00. You can register for the webinars and find recordings of previous webinars on our website at [ACEsAware.org/educational-events](https://www.acesaware.org/educational-events). And a recording of this webinar as well as the transcript and the slides will be posted [ACEsAware.org](https://www.acesaware.org) by early next week. Thank you all for joining today. Thank you so much to our wonderful presenters. Please be sure to visit [ACEsAware.org](https://www.acesaware.org), and follow us on social media. And we hope to see you at the next webinar on May 27th. So thank you for everything you are doing for your patients and stay safe everyone. Thank you.